Transforming Indiana's Behavioral Health System for Children and Their Families

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Acknowledgement

The following document was written at the request of Indiana's Transformation Team. It represents a vision that has evolved over the past ten years. Input has been solicited from community providers, families, advocates, and the multiple state agencies/systems that serve Indiana's children and youth. It is submitted to Indiana's Transformation Work Group for discussion. Public comment is also needed.

Introduction

State (Boggs, 2005) and federal (New Freedom Commission on Mental Health, 2003; SAMSHA, 2005) policy calls for the transformation of mental health care to achieve the promise of recovery so that individuals are able to live, work, learn, and participate fully in their community. Access to effective treatments and support services are necessary to realize this promise (NFCMH, 2003). Transformation is by definition more than reform; it "represents the bold vision to change the very form and function of the mental health service delivery system to better meet the needs of individuals and families it was designed to serve….it will be a complex process that proceeds in a non-linear fashion and that requires collaboration, innovation, sustained commitment, and a willingness to learn from mistakes" (SAMHSA, section 5, 2005). Why is transformation needed? What does transformation mean for the behavioral health system for children, youth and their families in Indiana?

Need for Transformation

The mental health and substance use needs of children and youth have been characterized as "constituting a public health crisis for our nation" (Subcommittee on Children, p. 1, 2003). It seems that a growing number of children and families are being affected with adverse impacts on multiple life domains, often with costly and tragic outcomes. In spite of heightened public awareness regarding such unmet needs over the last twenty years (Knitzer, 1982), a comprehensive, systemic approach to effectively promote, preserve, and restore children's mental health does not exist (Subcommittee on Children, 2003). Children with behavioral health needs are often involved in more than one public service system. Families describe the service delivery system as a maze with poor access and limited services (NFCMH, 2002). After reviewing data on how mental illnesses affect morbidity, mortality, and disability among children, The National Advisory Mental Health's Council's Workgroup on Child and Adolescent Mental Health (2001, p. 1) concluded that "no other illnesses damage so many children so seriously" Fifty percent of the children in the child welfare system (Burns et al., 2004) and 70% of children in the juvenile justice system (Skowyra & Cocozza, 2006) have behavioral health needs. Indiana's suicide rate has been higher than the national average for nearly a decade (Indiana Suicide Prevention Coalition, 2006). Suicide is the third leading cause of death for Hoosiers, ages 15 to 24. For additional information about the scope of behavioral health needs, see Appendix A regarding expected prevalence, the significance of these needs, related costs and specific challenges for Indiana. Appendix B describes the current funding and service delivery system. Appendix C explores evidence based practice for children's mental health.

A Vision of Transformation for Indiana

In response to the request of Indiana's transformation leadership, this white paper presents a vision of a transformed behavioral health system for the children, youth, and families of Indiana. Input has been solicited from many individuals at the state and local levels. The rapidly expanding literature base is referenced. The vision is built around Indiana's assets and challenges. The emerging vision and strategies reflect best clinical practice and sound business practice. It is consistent with Indiana's Social, Emotional and Behavioral Health Plan for Children (Interagency Task Force, 2006). An assumption is made that the behavioral health system for children and their families includes mental health and substance abuse services, and that the system spans Indiana's child service agencies, providers, and funders.

INDIANA'S VISION

- **Children with behavioral health needs and their families will be able to live and function in their communities.**
- **Children and youth with behavioral health needs and their families will be able to access effective treatment and support services based on their needs.**
- **Services will be child centered and family driven, community based, and culturally competent.**
- **Early identification and intervention, with active parental consent, for children with high risks of mental health or substance use needs (child welfare, juvenile justice, and corrections) will be routine.**
- **Practice based evidence and evidence based practice will be integrated into the system of care for children and families.**
- **A sound business plan will be created to develop and sustain accessible, cost effective behavioral health services and supports for Indiana's children and their families.**
- **Funding will be coordinated to ensure more appropriate and integrated service delivery for youth with co-occurring disorders and other multi-system involved populations (Armstrong, Pires, Stroul & Wood, 2005).**
- **Families and stakeholders will be knowledgeable about mental health and substance use issues.**

Indiana's Vision Defined

Children with behavioral health needs and their families will be able to live and function in their communities. Children and youth and their families will be engaged in their communities, positive relationships, progress in school, graduate, and develop vocational skills. They will have stable, safe homes. Families of children with SED will be actively involved in their children's treatment, receiving support through the process. No parents will have to relinquish custody of their children to access needed services.

Services will be child centered and family driven, community based, and culturally competent. Underlying policy and practice across agencies is a consistent value and philosophy that maintains a focus on children with behavioral health needs and their families, emphasizes supporting children and families as close to home as possible, and is culturally sensitive. Effectively meeting identified needs is routinely measured by outcomes. Strengths are identified and built. Safety and health needs are addressed. Families are actively engaged in policy, services, and evaluation.

Children and youth with behavioral health needs and their families will be able to access effective treatment and support services based on their needs. Regardless of the service system or community in which needs are identified, children and families will receive timely, effective services based on their needs. Outcomes will be used to identify needs, inform care plans and level of care decisions, and measure outcomes. Resulting information will be used routinely by practitioners, supervisors, administrators and policy makers to improve the quality of practice. The social, emotional, and behavioral health needs of young children will be identified early and effective interventions provided. For children with multiple agency involvement, services are coordinated to develop an integrated plan and avoid duplication of assessments and services.

Early identification and intervention, with active parental consent, for children with high risks of mental health or substance use needs (child welfare, juvenile justice, and corrections) will be routine. Children in the child welfare and juvenile justice systems have high rates of behavioral health issues which impact daily living, placement stability, and the ability to learn. When needs are identified and addressed appropriately, children will have better outcomes.

Integrate the use of practice based evidence and evidence based practice into the system of care for children and families. Most states have chosen either a system of care philosophy or evidence based practices. Indiana's transformed system would build on system of care values and principles, child and family wraparound teams for children with complex needs, collect data to identify successes and needs (practice based evidence), and use the research base to identify evidence based practices to meet gaps in care and training needs.

A sound business plan will be created to develop and sustain accessible, cost effective behavioral health services and supports for Indiana's children and their families. Policy, funding, and quality improvement processes, will be developed to support the clinical model. A sound plan will include collaboration and integration of agencies' policies, rules, and practice. Where possible, the same outcome measure/metrics will be used across systems. Policies involving DMHA and Medicaid would be blended regarding standards, rules, and implementation requirements. Data would be used to inform policy decisions and for quality improvement purposes.

Funding is coordinated to ensure more appropriate and integrated service delivery for youth with co-occurring disorders and other multi-system involved populations (Armstrong, Pires, Stroul & Wood, 2005). Between agencies funding will be coordinated to maximize federal resources, to reduce duplication, and to support effective services.

Families and stakeholders will be knowledgeable about mental health and substance abuse issues. Information about child social, emotional and behavioral development and needs will be made available through culturally sensitive strategies. Families, other health care, education, and service providers will have easy access to information behavioral health needs, effective treatment. It will be commonly understood that good mental health is essential to good health (HHS, 1999).

ACHIEVING INDIANA'S VISION: STRENGTHENING CHILDREN'S BEHAVIORAL HEALTH SERVICES

Key strategies are suggested to transform Indiana's behavioral health system for children and families. More detailed planning is required to implement such strategies. Some of these strategies reflect work that is currently underway.

Developing Comprehensive Home and Community-Based Services and Supports

- Build the capacity for comprehensive home and community based services and supports, such as intensive home-based care, day treatment, mentoring, respite care, wraparound through child and family teams, and therapeutic foster care, a full range of both nonresidential and residential services and supports that go beyond traditional office-based outpatient, inpatient, and residential treatment (Huang et al., 2005).
- For children with high expected rates of behavioral health care (in child welfare and juvenile justice systems), provide early identification and effective interventions (NFCMH, 2003).

Interagency Collaboration

- Build and sustain the foundation of growing interagency and family collaboration (system of care) (Stroul & Friedman, 1986) at the service delivery, policy, and evaluation levels.
- Implement a common assessment tool and quality outcome management processes (CANS) (Lyons, 1999) across Indiana's child service systems.
- Ensure clear interagency communication through a common language, common assessment tools/quality improvement processes.
- Use information from outcome quality management tool, CANS (Lyons, 1999), Consumer Service Review (CRS) (Groves, 2006), and claims/encounter data to inform policy and planning decisions on a statewide interagency level.

Sound Business Plan

- Provide a broad array of effective treatment and support services for children with mental health needs and their families (within 200% of poverty) through public mental health, addiction, and Medicaid funds.
- Coordinate behavioral health prevention and treatment services/funding for children, youth and their families to reduced fragmentation, duplication, gaps, inefficiencies, and cost shifting. Incrementally, develop business strategies to address identified complex unmet needs which have potential costly consequences (e.g., school failure, relinquishment of custody, institutionalization, and criminal behavior).
- Incorporate outcome measures and quality improvement processes in performance based contracting with providers.
- Revisit the State Medicaid Plan, making changes to support the development and provision of effective intensive community based services for children and their families.
- Combine a variety of funding mechanisms and resources to provide the flexibility and breadth needed to coordinate and pay for comprehensive intensive home and community based services (Ireys, Pires, & Lee, 2006).

Quality Improvement Processes

- A common tool/outcome quality management process will be used to assess the behavioral health needs and strengths of children and families across the child service systems, to individualize care (Huang et al., 2005), to inform level of care decisions, and to measure outcomes.
- Data from the assessment tool will be used routinely to adjust plans of care, inform level of care decisions, measure outcomes, identify gaps in service system, identify successes and the need for research based interventions and training.
- Use a combination of national wellbeing indicators such as the wellbeing of Indiana's children (Casey Foundation, 2006), National Outcome Measures (NOMS) (SAMSHA, 2006), and improvement in symptoms and/or functioning as evidenced system wide by the CRS (Groves, 2006) and for individual children and access to needed services by the Child and Adolescent Needs and Strength (CANS) (Lyons, 1999), for quality outcome management to improve the service delivery system.
- Create database and routine reporting (from CANS) to clinicians, supervisors, agency quality improvement staff, and state agencies.
- Practice Based Evidence. Use data to identify successes (promising or future evidence based practices), the need for improvement, and gaps in care.
- Use research to address identified needs for improvement/gaps in care.
- Evidence Based Practices. Integrate targeted evidence based practices (EBPs) into the system of care through training, support, funding, fidelity monitoring, and outcome measures. This will require explicit values and principles, a clear direction and goals, and a strong performance measurement system (Friedman & Drews, 2005).
- Monitor intended and unintended consequences of policy decisions, making changes as needed.

ACCESS TO CARE

- Make behavioral health treatment and support accessible within reasonable time frames with flexible schedules and locations.
- Better address early childhood mental health needs in partnership with health providers and services that routinely work with this population of concern.
- Provide school based behavioral health services (with parent's active consent and participation).
- Develop strategic plans to increase culturally competent care and to reduce unmet need and disparities for children of racially and ethnically diverse backgrounds. Include the voices, views, and recommendations of diverse ethnic and racial groups. (Huang, et al., 2005).

WORK FORCE DEVELOPMENT

- There will be a sufficient number of well trained service providers to delivery a broad range of effective models of care for behavioral health and addiction treatment in Indiana.
- State agencies, higher education, and providers will collaborate to identify workforce needs, recruit young professionals (psychiatrists, psychologists, social workers, nurses, special education, and counselors) to the field, and to address the ongoing training needs of mature professionals in the field.
- Case managers, care coordinators will be highly trained and supported in their work.
- Peer and family support will be strong statewide and integrated into the service delivery system.

Appendix A. Population of Concern: Need

- The problem is large and seems to be growing with 20% of all children affected by behavioral health needs. 9 to 13% of children (ages 9 to 17) have serious emotional disturbances (SED) with *significant* functional impairments; 5% to 9% (ages 9 to 17) have SED with *severe* functional impairments in other life domains (Farmer, Stangl, Burns, Costello & Angold, 1999).
- Research indicates a high prevalence of emotional and behavioral problems for preschool children (Lavigne et al., 1996). Neuroscience advances reveal the impact of environmental factors on brain development and early psychosocial behavior, supporting an argument for early detection, assessment, and treatment to prevent mental health problems from worsening (Shonkoff & Phillips, 2000).
- 50% of the children in the child welfare system (Burns et al., 2004) and 70% of children in the juvenile justice system have behavioral health needs (Skowyra & Cocozza, 2006).
- 70% of children and adolescents in need of treatment do not receive mental health services (DHHS, 1999). Both serious and long lasting, emotional disturbances can lead to tragic consequences: poor academic achievement, failure to complete high school, substance abuse, involvement with the legal system, lack of vocational success, inability to live independently, poor health, and suicide.
- Youth with SED, not only have diagnosable disorders, but also have impairments in vital life domains: family, education, peers, works, and community.
- The human and financial costs of emotional problems for children affect the children and their families, schools, communities, employers, and the state as a whole. Nationally in 1998, expenditures for mental health services were $11.75 billion (Rand, 2001).
- SED occurs in children of all socio economic groups. However, a disproportionate number of low-income children experience emotional problems and a disproportionate number of low-income and racial and ethnic minority youth do not access behavioral health services. Only 25% of children with serious emotional disturbances have recently received mental health care (Costello, Messer, Bird, Cohen & Reinherz, 1998). Some researchers suggest that the first contact with the mental health system for many African American youth is through the juvenile justice system.
- Children with emotional problems are often involved with more than one other specialized child service system—mental health, special education, child welfare, juvenile justice, substance abuse, health, corrections—but no agency or system is clearly responsible or accountable for them. “Growing numbers of children are suffering needlessly because their emotional, behavioral, and developmental needs are not being met by those very institutions which were explicitly created to take care of them” (HHS, 2000, p).

Indiana is ranked 32nd among 50 states for children's overall well- being (Casey Foundation, 2006)

Indicators

% low-birth weight babies (live births weighing less than 5.5 pounds)
Infant mortality rate (death rates per 1000 live births)
Child death rate (deaths per 100,000 children ages 1-14)
Teen death rate (deaths per 100,000 teens age 15-19)
Teen birth rate (births per 1000 females 15-19)
% of teens who are **high school dropouts** (16-19)
% **of teens not attending school & not working** (16-19)
% of children living in families where **no parent has fulltime, year round employment**
% of children living in **poverty**
% of children in **single-parent** families

Indicators	IN 2000	IN 2003	National 2000	National 2003
% low-birth weight babies	8.3	8.9	7.6	7.9
Infant mortality rates	6.7	5.8	6.9	6.9
Child death rate	27	37	22	21
Teen death rate	81	85	67	66
Teen birth rate	42	41	48	42

Indicators	IN 2000	IN 2004	National 2000	National 2004
% of teen high school dropouts	13	13	11	8
% of teens not attending school & not working	10	10	9	9
% of children whose parents lack full time work	27	33	32	33
% of children in poverty	14	15	17	18
% of children in single-parent homes	29	28	31	31

Related to Indiana's high KIDS COUNT Indicators….

- Indiana's suicide rate has been higher than the national average for nearly a decade. Suicide is the 3rd leading cause of death for Hoosiers 15-24 (IN Suicide Prevention Coalition, 2006). According to the 2005 Youth Risk Behavioral Survey, of Indiana's 9th through 12th graders, 22% of girls and 14.3% of boys had seriously considered attempting suicide in the last year. This is up from 18.9% of girls and 13.3% of boys in 2003 (Eaton, et al, 2005).
- An overall 72% high school graduation rate is reported for Indiana by Toppo, Lochner & Moretti, (2006). The impact of serious emotional disturbances on learning is well documented; only about 42% of these students graduate from high school, compared with 57% of all students with disabilities (DOE, 2001).
- 82% (120,025) of Indiana's children whose parents do not have a high school education live in low-income families (National Center for Children in Poverty, 2006).

Appendix B. Indiana's Child Behavioral Health Service Delivery System: Assets and Challenges

Funding

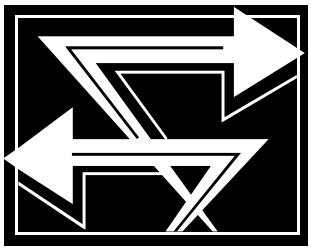
- The two primary funding sources for specialized mental health services for children whose families are at or below 200% of poverty are Medicaid and public mental health funding.
  - Indiana Medicaid costs for children's behavioral health care in SFY2005 exceeded $147,544,987 plus pharmacy costs. Since the implementation of the Child Welfare Mental Health Early Identification and Intervention in July 2004, the average cost of behavioral health services for children in the child welfare system has dropped from $3976/child to $2472/child (based on analysis of SFY05 claims data through 9/30/05) (Wright, Lawson & Quantz, 2006). This compares with Medicaid behavioral health costs of $2184/child in SFY04 to $1957/child in SFY05 (through 9/30/05). Behavioral health services for about 20% of the children in the child welfare system are funded by Medicaid.
  - In SFY2005, 29, 825 children were enrolled in DMHA's community service data system as eligible for public mental health funding. Due to limited resources, services for less than half of the children were funded at a flat rate of $1607/child. Public mental health $ are complemented by Medicaid (clinic and rehabilitation options), private insurance, and fees.
- Behavioral health services are also financed through other child service systems; 75% of services (community based and residential) for children in the child welfare system are paid by a combination of local, state, and federal dollars; the education and the correctional system also fund community based services and residential care. Early childhood social emotional development and intervention is assessed and funded through First Steps.
- Behavioral health services for children above 200% poverty are primarily funded by private insurance, usually through a managed care plan that covers limited outpatient and inpatient care. Coverage does not usually cover intermediate or intensive levels of treatment. There is a lifetime coverage limit on many plans.

Available Mental Health and Substance Abuse Services

- Community based mental health services include traditional outpatient, facility based crisis services, supportive and intensive case management. Intensive community based services through child and family wraparound teams are available in more than half of the counties, serving about 1000 youth across the state.
- Three state hospitals provided services to 152 children through 90 beds and youth in SFY2005.
- In February 2005, a 1915c Home and Community Based Medicaid waiver for children with SED was approved for a 3 year demonstration. Built on the child and family wraparound model, the waiver targeted children who might otherwise be at risk of being hospitalized in a state hospital.

Services…….

- In January 2005, psychiatric treatment facilities were funded by Medicaid and child welfare. This program has grown to a $25M/year program in two years. Prior to this, parents had to relinquish custody of their children to access residential care.
- Child Welfare Mental Health Early Identification and Intervention Initiative began statewide January 2005. Children who are placed in substitute care or adjudicated CHINS by child welfare are screened for behavioral health needs. If a possible behavioral health need is identified, the child is referred to mental health professional for assessment and feedback regarding needs and level of care. Data sharing between child welfare, mental health and Medicaid has made evaluation by IUPUI.
- Most children in residential care are wards of the state with costs paid by local, state, and federal child welfare funds. Education and the correctional systems also pay for residential care.
- Foster care is available through county child welfare offices; therapeutic foster care, as defined by state licensure rules, is purchased by child welfare from private child placement agencies.
- Child welfare licenses all levels of residential care for children. There is no centralized record of residential costs. Records are county based.
- School based behavioral health services are available at varying levels through special education, student services, health clinics, and on-site services by local providers.
- Social, emotional, behavioral health assessment training for early childhood professionals is provided by First Steps, Step Ahead, Head Start, mental health, and the health department.



Access to Services

Child service systems are separate and services are often fragmented**.** Families and referral sources report difficulty accessing timely services. Crisis services are usually limited to determining eligibility for scare acute inpatient care. Children and families often face long waits to be seen for outpatient services. A maze of requirements excludes many children with SED and significant or severe functional impairments are not eligible for intensive community based services due to eligibility exclusions (income limits, managed care limitations, exhausted health insurance, not fitting the targeted population, and limited intensive community based care). Although interagency collaboration has begun, each system operates with separate policies, targeted funding, and separate databases.

Appendix C. Evidence Base for Children's Mental Health

An evidence base for children's mental health is accumulating. About 40 research based interventions have been documented as efficacious in improving specific emotional and behavioral health symptoms experienced by children (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001). It is important to identify which evidence based practice (EBP) works well with which children. For example, cognitive behavioral therapy and exposure are considered to be EBPs for children with anxious or avoidant behaviors (Evidence Based Services Committee, 2006). Often there is a 20 year lag in the dissemination of evidence-based practices into practice.

Challenges. Many interventions have not been tested on the highly diverse population of children who are usually served in the public mental health system, children with multiple needs, problems, and co-occurring conditions (Friedman & Hernandez, 2002). Evidence based interventions have not been identified for all problems and needs, and, even when available, do not work consistently with all families (Huang et al., 2005). Burns and Hoagwood (2002) concluded that multimodal interventions are most effective for children with complex problems, such as intensive case management (Evans & Armstrong, 2002; Hoagwood et al., 2001), treatment foster care (Chamberlain, 2002), Multisystematic Therapy (Henggeler, Schoenwald, & Pickrel, 1995; Henggeler, Schoenwald, & Munger, 1996). However, manualized programs most frequently cited as evidence based have usually served children other than children with serious emotional disturbances (Friedman & Drews, 2005).

Effective Implementation. When EBPs are implemented in practice settings, effective implementation must be planned, supported, and monitored to sustain fidelity to the model and to measure outcomes.

Practice Based Evidence. When an evidence base has not yet been developed, it is important (Huang et al., 2005) to (a) work with families and use the best clinical consensus to make decisions (b) support innovative efforts to develop new interventions at the same time that evidence based practices are disseminated, and (c) identify promising practices in the community for further evaluation (Weisz, Sandler, Durlak & Anton, 2005).

Appendix D. Glossary

Assessment. Assessment is a comprehensive, individualized examination that is lengthy and labor intensive (i.e. multiple interviews, record reviews, collateral contacts, and sometimes, psychological testing). Assessments are usually administered by trained mental health professional to evaluate the type and extent of mental health or addiction disorders in order to make treatment recommendations, level of care determination, and establish outcome measures (Grisso & Barnum, 2000 & Grisso & Underwood, 2004).

Behavioral Health. Behavioral health includes treatment and rehabilitation for mental illnesses and addictions disorders including medical, social, psychological and rehabilitation services to help people with mental illnesses and addictions disorders recover and lead productive lives (National Council for Community Behavioral Healthcare, 2006). Addressed are a wide range of concerns including a range of psychiatric diagnoses (e.g., ADHD and anxiety), related symptoms (e.g., tantrums and tics), and social problems (e.g., social skills and sibling rivalry) (Cooper, Valleley, Polaha, Begeny & Evans, 2006).

Clinician. "Clinician means any individual who is qualified to provide counseling, therapy, case management, or like services" (DMHA; 440 IAC 9-1-3).

Evidence Base. Definitions of evidence-based practices (or effective models of care) have been developed by many national organizations, including the Institute of Medicine (2001) and American Psychological Association (Chambless, 1998). Additionally, states, such as Hawaii (Evidence Based Service Committee, 2006), have created definitions of effective models of care that reflect the values of their system of care. The importance of effective models of care in a transformed mental health system is highlighted by the creation of New Freedom Commission on Mental Health Subcommittee on Evidence-Based Practices (2003). In Indiana, the following issues must be addressed in order to identify, develop and implement effective models of care:

- Defining effective models of care
- Assessing readiness for change (Procheska, DiClemente & Norcross, 1994 & Rogers, 2003)
- Applying implementation research (Fixsen, Naoom, Blasé, Friedman & Wallace, 2005)
- Measuring fidelity
- Tracking outcomes
- Using data for quality improvement

Functional Impairment. Functional impairment is defined as "difficulties that substantially interfere with or limit role functioning in one or more major life activities, including basic living skills (e.g. eating, bathing dressing); instrumental living skills (e.g. maintaining a household, managing money, getting around the community, taking prescription medication) and functioning in social, family, and vocational/educational contexts" (Section 1912 (c) of the Public Health Services Act, as amended by Public Law 102-321.

Provider. " 'Direct services provider' means any individual, a contractor, employee, or volunteer who providers counseling, psychological, medical or social services on behalf of a provider of addiction treatment services" (440 IAC 4.4-1-1). Entities which may be certified as addiction treatment providers include individuals, firms, corporations, partnerships, associations, foundations, governmental units, or agencies, whether public or private. Mental health providers could be certified community mental health centers (440 IAC 4.1-1-1, 440 IAC 9-1-4), managed care providers (IAC 9-1-9) or individuals eligible to provide mental health or addiction services under Medicaid regulations or private insurance standards and requirements.

Recovery. "Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual's recovery" (New Freedom Commission on Mental Health, 2003).

*Resilience***.** Resilience refers to the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses—and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem-solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing support for their members (New Freedom Commission on Mental Health, 2003).

Screening. "Most definitions of screening for mental health and substance use problems describe a relatively brief process designed to identify youth that are at increased risk of having disorders that warrant immediate attention, intervention, or more comprehensive review" (Grisso & Underwood, p. 6, 2004).

Serious Emotional Disturbance. "Children with serious emotional disturbances are persons from birth to age 18 who currently, or at any time during the past year, have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994) that resulted in functional impairment which substantially interferes with or limits one or more major life activities" (CMHS, 1999, page 1).

System of care. In Indiana and nationally, the state and local communities are working to develop and implement a system of care consistent with the following definition: "A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families" (Stroul & Friedman, 1986). To effectively promote children's social, emotional and behavioral health, however, the concept of a system of care must be viewed more broadly to include coordination of services and supports across all of the agencies, organizations and individuals that work to improve outcomes for children and

families at the state, regional, county and community levels. The system of care includes the full continuum of services, including services delivered in the community, by child-serving agencies, in residential treatment settings and state hospitals. Minimally, a system of care includes mental health and addiction, child welfare, education, juvenile justice, corrections, and families.

Transformation. Transformation refers to the process of improving the mental health system for the purpose of improving access to quality care and services (The New Freedom Commission on Mental Health, 2003). Successfully transforming the mental health service delivery system rests on two principles: consumer and family centered services and increasing consumers' ability to successfully cope with life challenges, on facilitating recovery, and on building resilience. Traditional reform measures are not enough. To fundamentally transform how mental health is delivered in America, six intertwined goals were recommended (Hogan, 2005):

- Establish Mental Health as Essential to Health
- Provide Consumer and Family Centered Care
- Eliminate Disparities in Mental Healthcare
- Early Mental Health Screening and Treatment Across the Lifespan
- Provide the Best Care Science can Discover
- Capitalize on Technology

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